CORESS
CONFIDENTIAL REPORTING SYSTEM IN SURGERY

CORESS FEEDBACK

Here are two feedback accounts that the panel selected as interesting and educational. They are both set in the operating theatre, which is probably unsurprising as this is a complicated multifaceted environment. One of the bosses of a member of the panel used to emphasise the importance of assessing the 'screw-up' factor in any situation and to take appropriate actions to minimise it. A useful concept, we are sure you will agree. We are grateful to the reporters and hope that this will stimulate others to submit. Remember, the feedback reports are heavily edited to make them untraceable and are also dislocated in time. We do need contact details for verification and to check pertinent details that will help to pin down the salient facts. The contact details of the reporter are never held on computer and, after processing, the link between the reporter and the final report is permanently broken by returning the original to the reporter.

A useful source of reports has been found to be the M & M meetings that each department in every hospital holds. If there are messages of general interest in a particular case, why not ask the team to write a report for CORESS as one of the outcome measures?

The CORESS Reporting Form, which includes the "Freepost" address to which it can be returned, is downloadable from the Association's website at: www.asgbi.org.uk

PARALLEL LISTS AND A TOUCH OF FARCE?

Parallel lists that included a flexible sigmoidoscopy/colonoscopy in one theatre and a circumcision on the other were being conducted in adjacent theatres, each under the supervision of a consultant.

The consultant conducting the sigmoidoscopy list collected Mr Brown himself. He did not use the paper checklist. Mr Brown was very hard of hearing and answered questions about his bowel habit (which was abnormal, as it happens – he was very elderly) and proceeded to have flexi-sigmoidoscopy. The case notes comprised a 'temporary folder' as the originals were not available on the day of admission. It was then noticed by one of the nursing staff that he was the 'wrong' Mr Brown. The mistake was explained to the patient. Fortunately, he was pleased that he had undergone sigmoidoscopy because of his bowel symptoms. He then underwent the circumcision for which he had been booked. There were no complications and the patient wrote later to thank the team for being so attentive and exceptionally thorough!

CORESS Panel Comment

We are very grateful to the home team for letting us have sight of this case. Fortunately, no harm resulted from the occurrence. The panel felt that there are a number of issues that are pertinent to this episode.

Consultants bypassing safety systems. We suspect that the consultant went to collect the patient him/herself either to be helpful or because of a lack of 'logistical support staff' – porters to you and I. We do not have the details on this point, nor the reasons why all the other systematic checks seem to have failed to pick up the error. Waiting interminable lengths of time between cases on poorly staffed/organised theatre lists is exasperating. Nonetheless, and whatever the prevailing circumstances, the team collecting a patient from the ward must understand the correct procedure and follow it. Particularly during these times when continuity of care is being fragmented. Perhaps the lack of a proper set of case notes should require a more thorough review of the patient by the admitting team or postponement of the procedure. The NPSA recently issued a safety alert on correct site surgery aimed at just these issues. It can be viewed at www.npsa.nhs.uk One way and another, the message is clear - put safety first and spare yourself a lot of paperwork and some broken sleep!

Team working. The surgeon conducting an operating list bears ultimate responsibility for the patient's care in the theatre and must be able to act decisively according to circumstance. One must ask, however, why other members of the team did not question or press home to the consultant the importance of following the correct procedure. Perhaps one or more of them did and was over-ruled? Perhaps it was a combination of circumstances and everyone took their eyes off the ball at the same time? It must be emphasised that it is in the best interest of surgeons, their teams and the patient that each member of a theatre team remains vigilant, understands the importance of considering patient safety at all times and realises that he/she has a responsibility to make any concerns known to the surgeon.

Note: CORESS is particularly keen to hear of any other episodes of a similar nature relating to correct site surgery as these are very relevant and particularly instructive to all of us managing a team in the operating theatre. It would be helpful if as much detail as possible could be supplied i.e. the situation in detail and why things were as they were, team interactions (who said what to whom, etc). The reports will be subject to the usual procedure of analysis after reporter details have been removed and the text altered to preserve the points but remove any identifiers.

TRAINERS: NEVER DROP YOUR GUARD!

A 65 year old diabetic woman was taken to theatre with a critically ischaemic hand relating to a probable embolus.

The surgeon states that his usual plan was to prepare the limb with a widely used preparation containing iodine - a very 'brown' liquid. The patient was allergic to iodine and, therefore, another solution containing chlorhexidine was substituted. On previous occasions this had been presented as a pink-coloured preparation but this time the solution offered was clear. The surgeon states that he queried the reason for this with the theatre nurses and was told that it was "because there were difficulties with supply and the pharmacy could no longer produce this economically".

The registrar was to carry out the procedure, with the consultant assisting and supervising at the table. The embolectomy was carried out and the routine at that time was to carry out on-table angiogram to assess the result. The theatre nurses had developed a system of decanting several ampoules of contrast into a galley pot on the instrument tray in order to expedite the process. The nurse had checked the ampoules as she drew up from them and the ampoules would also usually be displayed to the surgeon at the nurse's prompt before the contrast was injected. When the moment arrived for direct injection into the brachial artery a 10ml syringe full of colourless liquid was handed to the trainee who was about to inject it without comment from either him or the trainer when the nurse said that she thought that she may have drawn up skin prep in error. On checking, it was clear that the syringe did, indeed, contain skin prep.

Following this, there was a general review of risk management in the theatre suite and specifically all teams were reminded that <u>any substance</u> that is to be injected into a patient during surgery <u>must</u> be drawn up in front of the surgeon.

Reporter Comments

There were many mistakes here, including:

1 The decision for the removal of colouring from the skin prep had been taken without due regard for its safety implications and without reference to the surgical teams.

2 The nurse staff in theatres had failed to treat injectable material (radiographics) in the same manner in which they would treat other injectables i.e. drawn up in front of the surgeons from ampoules shown to, and checked by, the surgeon.

3 The ultimate checking mechanism, the surgical trainer (and trainee), failed to insist on being shown the intact ampoules and having the material drawn up in front of him/her.

CORESS Panel Comment

We cannot help but agree with the reporter on all the points he makes about this very near miss. The account particularly highlights how the overall safety of a system can be eroded insidiously over a period by removal, one by one, of a series of checks until only one last defence remains. When this fails, as it is bound to do at some point, a mishap is inevitable. The 'Gruyere cheese' effect.

Designers of systems understand this principle very well and build in as many checks at critical points as possible commensurate with efficient working. They achieve this by a critical analysis of the completed system and applying the 'what if' factor at each step. In this way the critical points can be identified and a solution applied. It is rarely, if ever, a good idea to be dependent on one check. Furthermore, the removal of any routine safety check, (such as the omission of colouring of the skin prep, the decanting of injectables into galley pots) should only be permitted under exceptional circumstances and after all users of the system have been made aware of the deficiency.

The lack of vigilance of the surgeon and his/her trainee will not have escaped notice and again illustrates how easy it is for a momentary lack of concentration to result in disaster and how an unsafe practice can be permitted to evolve over a period of time in full view of all concerned, presumably without any questions having been raised previously. It is also pertinent to note that surgical trainers cannot afford to relax at any point during the proceedings and that he/she bears ultimate responsibility. Perhaps each of us needs to look at the details of our team's work in our theatres through the eyes of a safety inspector?

Our thanks, as usual, to the reporter for this report and the insights.